Meeting Summary

eHealth Technical Advisory Committee
February 23, 2010 12:00-1:30PM

Summary of Key Questions/Issues/Decision Points:

- The 2/9 and 2/16 meeting summaries have been approved.
- TAC members have significant concerns about CalPSAB's current recommendation that HIE be limited strictly for the purposes of clinical care and public health. There is additional concern about the implications of an opt-in approach affecting routine information exchange such as lab results and eligibility checking. A TAC response addressing these concerns will be formulated as feedback to CalPSAB.
- While there appears to be broad recognition of the importance of addressing patient identification, there remain significant questions around how to approach the issue. Different opinions were expressed in favor of either Option 1 (design a centralized patient identification service now) or Option 2 (assess and accommodate the patient identification requirements of high priority services first, and use this as the basis for deciding if a centralized patient identification service is warranted). Concerns were also raised that there was not enough information to make a decision on either option at this time. A framework for further analysis that can help to drive the decision is needed.
- There were no stated objections to releasing the technical architecture draft as-is to the public for comment. In particular, there were no stated objections to keeping the Health Record Correlation Service as part of the architecture.

Next Steps:

- Members are asked to please review the draft operational plan on the Wiki and submit edits/comments by 2/26, with a special focus on identifying areas of inconsistency with other workgroups.
- Scott Whyte, Wayne Sass, Terry Hearn, and John Mattison will formulate a response to CalPSAB that articulates the concerns of TAC about current recommendations pertaining to HIE.
- Next meeting is scheduled for Tuesday 3/2 12-1:30PM.

Detailed Meeting Summary:

Approval of Meeting Summaries

Laura Landry motioned and Wayne Sass seconded that the summary of the 2/9 meeting be approved. There being no objections, the 2/9 meeting summary was approved by TAC.

Walter asked whether there was anyone on the call who was not prepared to approve the 2/16 meeting summary. There being none, Wayne Sass motioned and Rama Khalsa seconded that the summary of the

2/16 meeting be approved. There being no objections, the 2/16 meeting summary was also approved by TAC.

Updates on environmental issues

"Compartmentalization" of funding

Last week, ONC issued clarification on the State HIE Cooperative Agreement Program delineating two main funding streams for HIE. One category of funding is intra-state HIE, while another category is nationwide (inter-state) HIE. In total, $16.5M of the $38.8M awarded is earmarked for inter-state HIE, which could include either NHIN-related activities or HIE that crosses state boundaries. The group was asked what practical implications this might have for the technical architecture. The following comments were made on this issue:

- Jonah Frolich reported that ONC has not provided further guidance on what activities would be considered supportive of intra-state vs. inter-state HIE. Until such time that there is further guidance (if any), it will important to clearly designate to which funding category each expense belongs (e.g., creating an NHIN gateway, adopting national standards, etc.).
- John Mattison commented that aligning California's HIE efforts with NHIN will have the effect of simplifying the accounting task, since in that case whatever is used for intra-state HIE can also be used for inter-state HIE.
- Linette Scott noted that the relationships that public health at the state level has with its 58 counties and 51 local public health systems are in many ways similar to state-to-state relationships due to the high level of local autonomy. Thus, many of the approaches normally taken by other states for inter-state HIE may very well apply to intra-state HIE in California.

Privacy/Security

CalPSAB's current recommendations are that HIE only be allowed for clinical care and public health. CalPSAB and OHII are working towards expanding the permissible scope of HIE, but the issue needs to go through their analysis process. As it stands, this would exclude services aimed at administrative simplification, such as the patient eligibility checking services that TAC has been discussing. It is unclear whether CalPSAB has an accurate definition of "health information exchange" and "health information infrastructure." The following discussion points were raised about this issue:

- Terry Hearn stated that her understanding from CalPSAB is that the board was not addressing HIE for administrative purposes because of the pre-existence of HIPAA, which already covered this area. Walter and Wayne both reported that the message given by CalPSAB in the last call as well as in its current guidelines is that acceptable purposes of HIE do not include administrative purposes. The board plans on eventually expanding the allowable use of HIE to other areas, but initially only clinical care and public health will be included.
- Terry Hearn and Scott Whyte voiced concern whether HIE for the purposes of care management/disease management by payers would be allowed, being that this function is of great importance to the effectiveness of clinical care and clinical information exchange.
- John Mattison stated that once exchanged clinical data is incorporated into an organization's patient record, the data is used not only for clinical care but for other purposes such as billing

and quality improvement. Thus, limiting acceptable use of HIE to clinical care and public health would be impractical.

Additionally, there is an ongoing debate within CalPSAB about whether patient consent for HIE will be based on an opt-in or opt-out model. While the board is currently split on which approach to take, the most recent suggestions from Bobbie Holm are to "plan on an 'opt-in' process for everything." She has also suggested that given the direction of talks around the consent issue, a consent management service be considered as part of the technical architecture. If adopted, the opt-in policy would require explicit opt-in consent by the patient for every type of electronic exchange of health information, including information that is currently exchanged on paper without explicit consent. The question was posed to the group of whether an opt-in consent model would require a centralized consent registry, or if there might be another way to address the issue.

Jonah Frolich encouraged TAC members to provide feedback on the implications of the privacy/security decisions of CalPSAB. He expressed particular concern that certain routine exchanges of information would require consent, including eligibility transactions and reporting of lab results. In his view, the Governance Entity would need to have a process by which it will be able to set appropriate guidelines for such transactions.

Walter suggested that a clear action item for TAC would be to formulate a statement about these concerns as feedback to CalPSAB. Scott Whyte, Wayne Sass, Terry Hearn, and John Mattison agreed to work on drafting this language.

<u>Patient identification as a CS-HIE service</u>

Walter presented two options to the group for consideration as to how TWG should best go about designing a patient identification service that meets the needs identified by TAC.

- Option 1: Design a centralized "registry", "MPI", or similar resource for patient identification. This is essentially what has been placed into the draft technical architecture as the Health Record Correlation Service—an explicit defined, separate, core service for patient identification.
- Option 2: Accommodate patient-identification requirements in the design of other core and non-core services; then, consider whether sufficient commonality exists in these requirements to suggest a single, centralized patient-identification resource.

There was a long discussion among participants regarding this issue. During the conversation, it became clear that there was confusion about the meaning and ramifications of the two options, and in fact what exactly is meant by "patient identification." It was also clear that there is a need to prioritize the services that can serve as the requirements for such decisions. In the end, the group was not prepared to vote on the appropriateness of one option over another.

Some more substantive specific comments included the following:

- Laura Landry stated that one question to ask is how a centralized patient identity service would be used for the purposes of HIE.
- Tom Williams asked if there was a staff recommendation for one of the two options. Walter replied that the staff position would be to support Option 2, since it leaves open the possibility of building a central patient identity service if needed, but does not jump to this conclusion prematurely. Option 1 presents substantial technical difficulties, and in fact may not be needed to enable the ultimate goal of health information exchange.
- Rim Cothren stated that Option 1 would be appropriate if TAC believes that the state has a responsibility to manage patient identities. On the other hand, Option 2 would be recommended if TAC believes that patient identification must be addressed within the context of other prioritized services. In this latter case, TWG would ask TAC to prioritize use cases for consideration by TWG to propose a technical solution meeting those requirements.
- Laura suggested focusing on prioritizing services on a roadmap, which could then be used to drive decisions regarding patient identification requirements.
- Wayne interpreted Option 1 as building a service to solve the issue of patient identification once and for all; Option 2 seemed to him to be leading to creation of multiple sub-optimal patient identification solutions, which would at some point necessitate Option 1.
- Terry Hearn observed that in her experience with matching patients to clinical data, it was absolutely necessary to have a centralized patient identity registry in order to deal with errors and incomplete information. She cited her experience associating patient lab results with clinical data about the patient as an example.
- Lucia Savage questioned why there is so much resistance in California for Option 1, when every other state with which she has been involved in HIE planning has decided to create a centralized patient identity service. Walter replied that many states are indeed planning to do so. However, the reality is that these services don't work that well, require a lot of manual intervention, and are expensive to operate and maintain. Terry Hearn noted that these services can be bought from vendors, and challenged the idea that they do not work well.
- Jeff Guterman suggested that for each use case identified, that three questions be raised with respect to patient identification: (1) what is the tolerance for Type I error (false positives), (2) what is the tolerance for Type II error (false negatives), and (3) is the use case required for meaningful use? Additionally, a separate cost analysis should be performed to give an estimate of how much potential benefit there might be in creating such a service once at the state level as opposed to multiple times in regions across the state.
- Tim Andrews observed that there are two distinct concepts related to patient identification that may be causing confusion among members of the group. The first is a specification of the rules based on legal and technical guidance that HIE participants will be required to comply with in order to identify patients, which he asserted is absolutely necessary in order for HIE to occur. The second part is what needs to be done to support the agreed upon specifications. This latter question appears to be what is causing confusion.
- There was interest in understanding how the NHIN handles the issue of patient identification. The NHIN does not have a patient identification service. It does provide a specification for how

organizations query each other with respect to patients, but does not suggest a particular mechanism of correlation.

Walter posed the question of whether or not to keep the Health Record Correlation Service in the draft document that will be circulated for public comment. In general, the opinions voiced favored keeping the draft as-is and allowing the public to provide comments before making additional changes. There were also suggestions made to draw attention to the patent identification issue to solicit public comment, as well as to change the name of the service to Patient Registry. However, neither suggestion garnered wider support from group members.

Members Present

Name	Title and Organization
Zan Calhoun	CIO, Healthcare Partners
Rim Cothren	TWG Liaison
Jonah Frolich	Deputy Secretary of Health IT, CHHSA
Jeff Guterman	Medical Director, LA County Dept. of Health Services
Terry Hearn	National Manager for Health Information Technologies, Wellpoint
Scott Joslyn	CIO, Memorial Care
David Joyner	SVP, Network mgmt, Blue Shield of California
Rama Khalsa	Health Director, County of Santa Cruz
Laura Landry	Executive Director, Long Beach Network for Health
Ronald Leeruangsri	County of Los Angeles Chief Executive Office
Ann Lindsay	Health Officer, Humboldt County
Mason Matthews	County of Los Angeles Chief Executive Office
John Mattison	CMIO, Southern California Region Kaiser Permanente
Greg McGovern	CTO, Adventist Health
Glen Moy	Sr. Program Officer, California Health Care Foundation
Ray Otake	CIO, Community Health Center Network
Ray Parris	CIO, Golden Valley Health Center
Angela Roberts	VP Administrative Services, Altamed Health Services Corporation
Wayne Sass	CIO and Privacy Officer, Nautilus Healthcare Management Group
Lucia Savage	Assoc. General Counsel, United Health Care
Linette Scott	Deputy Director, Department of Public Health
Terri Shaw	Deputy Director, Children's Partnership
Bill Spooner	CIO, Sharp Healthcare
Scott Whyte	Sr. Director for Physician and Ambulatory IT Strategy, Catholic Healthcare West

Staff Present

Name
Walter Sujansky
Tim Andrews
Peter Hung